TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
LONE STAR NEUROLOGY

Respondent Name
PLANO INDEPENDENT SCHOOL DISTRICT

MFDR Tracking Number
M4-18-0003-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
SEPTEMBER 1, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: Position summary was not submitted in dispute packet.

Amount in Dispute: $7,496.76

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The services billed did not include the 26 modifier or the TC modifier; therefore, both components were allowed when applicable. 95951-59-76 has a professional allowance of $501.08. 3 units were billed which resulted in a total payment of $1503.24…95957-59-76 has a whole procedure allowance of $474.04. 3 units were billed which resulted in a total payment of $1422.12. 93268-59-76 has a whole procedure allowance of $304.81. 3 units were billed which resulted in a total payment of $914.43."

Response Submitted By: Flahive, Ogden & Latson/ReviewMed

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 27, 2016 through October 29, 2016	CPT Code 95951-59-76 (X3)	$7,496.76	$0.00
	CPT Code 95957-59-76 (X3)		$0.00
	CPT Code 93268-59-76 (X3)		$0.00
TOTAL		$7,496.76	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
3. 28 Texas Administrative Code §134.1, effective March 1, 2008, provides for fair and reasonable

reimbursement of health care in the absence of an applicable fee guideline.

4. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines
5. The services in dispute were reduced/denied by the respondent with the following reason code:
   - P12-Workers' compensation jurisdictional fee schedule adjustment.
   - 18-Exact duplicate claim/service.

Issues

1. What is the applicable fee guideline?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The fee guidelines for professional services are found in 28 Texas Administrative Code §134.203.

2. 28 Texas Administrative Code §134.203(a)(5) states "Medicare payment policies" when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare."

   28 Texas Administrative Code §134.203 (b)(1) states, "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

   Per 28 Texas Administrative Code §134.203(c)(1)(2),

   To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.

   > (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32.
   >
   > (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year. The following hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division conversion factor of $50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the $51.90 (with the exception of surgery) Division conversion factor in 2007.

   To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) X Participating Amount = Maximum Allowable Reimbursement (MAR).

   The 2017 DWC conversion factor for this service is 57.5.

   The Medicare Conversion Factor is 35.8887

   Review of Box 32 on the CMS-1500 the services were rendered in zip code 75035, which is located in Frisco, Texas. Therefore, the Medicare participating amount will be based on the reimbursement for "Rest of Texas".

   Using the above formula, the Division finds the MAR is:

CPT Codes	Medicare Participating Amount for Professional Component	MAR	Carrier Paid	Total Amount Due
93268	$192.07	304.81 X 3 = $914.43	$914.43	$0.00

95957	$298.71	$474.04 X 3 = $1,422.12	$1,422.02	$0.00

According to Medicare fee schedule, CPT code 95951 does not have a relative value. Per 28 Texas Administrative Code §134.203(f), "For products and services for which no relative value unit or payment has been assigned by Medicare, Texas Medicaid as set forth in §134.203(d) or §134.204(f) of this title, or the Division, reimbursement shall be provided in accordance with §134.1 of this title (relating to Medical Reimbursement)."

28 Texas Administrative Code §134.1, requires that, in the absence of an applicable fee guideline or a negotiated contract, reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with subsection §134.1(f) which states that "Fair and reasonable reimbursement shall: (1) be consistent with the criteria of Labor Code §413.011; (2) ensure that similar procedures provided in similar circumstances receive similar reimbursement; and (3) be based on nationally recognized published studies, published Division medical dispute decisions, and/or values assigned for services involving similar work and resource commitments, if available."

Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.

28 Texas Administrative Code §133.307(c)(2)(O), requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) or §134.503 of this title (relating to Pharmacy Fee Guideline) when the dispute involves health care for which the division has not established a maximum allowable reimbursement (MAR) or reimbursement rate, as applicable." Review of the submitted documentation finds that the respondent paid $1,503.24 for CPT code 95951. The division finds the requestor does not demonstrate or justify that the amount sought for CPT code 95951 would be a fair and reasonable rate of reimbursement. As a result, additional payment cannot be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	9/27/2017 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.